THE WISCONSIN PARTNERSHIP PROGRAM

BUILDING A STATEWIDE SYSTEM OF CUSTOMER-RESPONSIVE, INTEGRATED CARE FOR PEOPLE WITH CHRONIC ILLNESS OR DISABILITY

PROJECT NARRATIVE

The Project Narrative is divided into eight (8) sections:

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I. Statement of the Problem

The Robert Wood Johnson Foundation, together with many states and nonprofit organizations, has invested heavily in reforming services for persons with chronic illness or disability. The viable projects created by these efforts have shown that integrating acute and long term care is cost effective. Successful models for doing so remain the exception, however. Moreover, systematic methods of developing and then replicating new, comprehensive, models of service delivery across both geographic and target group boundaries have not been demonstrated.

We propose to develop and implement a plan which both integrates acute and long term care and is replicable to multiple sites and populations. We call it the Partnership Program because it is based on new partnership relationships between constituencies, organizations, and funding sources. The Partnership Program will be home and community-based, consumer-responsive and quality-driven.

The Partnership Program is designed to eliminate fragmentation in long term care programs and of the health care system in general. Some harmful consequences of fragmentation include:

Unnecessary spending: Fragmentation in finance yields cost mismanagement. Each separate program and agency seeks to contain expenditures in its own area of responsibility, without regard to total cost. Rational acts, such as cost-shifting, contribute to an irrational and undesirable, total result.

Lower Quality of Care: Fragmentation in service delivery means that people depend on multiple providers who treat them not as whole persons, but as an unconnected amalgam of broken parts, illnesses, and conditions.

False Assurance of Quality: Fragmentation in finance and service delivery results in a compartmentalized quality assurance system. Each individual service is held to chosen standards, but the interrelationships between services are ignored. We are assured that each "part" is working fine even though the "whole" may be dysfunctional.

Resistance to Improvement: Fragmentation in management means that managers are responsible only for "parts" and no one is responsible for the "whole". Management is then blinded (and often resistant) to needed improvements.

Several demonstrations in the United States have attempted to address these problems. We turn to them in the next section. We narrow the discussion to a few of the most pertinent demonstrations which integrate acute and long-term care.

II. Related Demonstrations and Significance

There are three models in particular which provide background and experience on which to build the Partnership Program: The Social Health Maintenance Organizations (SHMOs), the Carondelet Model, and Program for All Inclusive Care for the Elderly (PACE).

The Social Health Maintenance Organizations (SHMOs) are four demonstration projects which attempted to integrate the services of HMOs with the services of social service agencies. The SHMOs were able to achieve varying levels of service integration, even though they did not successfully integrate medical professionals into multidisciplinary teams. Ultimately, the SHMOs experienced enrollment shortfalls and severe financial difficulties, and were unable to significantly reduce hospital utilization (Harrington and Newcomer 1991).

The Carondelet Model, a community model of nurse case management, utilizes a multidisciplinary team as the core of its service delivery, placing an emphasis on coordination of care across settings through the use of nurse practitioners as care managers. The resulting coordination of community and long term care planning is not as potent as full integration, but has shown positive results in early identification of treatable illness and shorter, less costly hospital stays (Ethridge, 1991).

The Program for All Inclusive Care for the Elderly (PACE), developed in San Francisco by On Lok, emphasizes prevention, rehabilitation, and maintenance services. PACE has demonstrated an integrated service delivery strategy which allows for early identification and treatment of health problems which results in reduced utilization of hospitals and nursing homes (Kane, Illston, and Miller 1992; Shen and Iverson 1992).

Discussion

Our research suggests that the potential for effectiveness in larger-scale programs, such as SHMOs, is unclear. Larger-scale programs risk losing focus while trying to serve participants with very different support requirements and may recreate much of the fee-for-service environment through their own subcontracting. Smaller programs which focus on special target groups have been reasonably successful in reducing fragmentation and maintaining high levels of quality and consumer satisfaction. In our opinion, PACE is the most coherent, integrated, and successful of these. Critics of PACE, however, cite certain limitations in service strategy. These limitations include:

1. The requirement that participants relinquish their current physician in favor of the PACE physician. This creates an enrollment barrier for some elderly.

2. Required attendance at an adult day center. This limits the program's appeal for some elderly and limits feasibility of the model in rural areas.

3. High start-up costs of $1.2M - $1.8M which impair replication.

In the Partnership Program, we propose to incorporate most elements of PACE with the exception of required day center attendance and mandatory physician assignment. We will include full Medicaid and Medicare capitation and full risk assumption after phase-in, comprehensive service delivery, and team-based care management. We will adopt the Carondelet approach of emphasizing the use of nurse practitioners to link services across sites. We propose to solve the "size versus focus" dilemma presented by the SHMOs by establishing an interconnected mutually reinforcing network of small, focused programs which individually resemble PACE but collectively enable service to a large number of people in both urban and rural areas.

III. Objectives of the Partnership Program

We will develop, implement, and research two consumer-responsive, managed care models which integrate acute and long term care through community-based organizations. One model will serve elderly people **(Partnership Program for Elderly People);** the other will serve people with physical disabilities **(Partnership Program for People with Physical Disabilities).** The models will:

- Provide comprehensive care to people who meet nursing home admission criteria;
- Improve functional and clinical outcomes of consumers;
- Retain the continuity of care and preventive health elements successfully incorporated in current PACE sites;

- Allow consumers to retain choice of primary care physicians and to participate in the program without attending adult day care;
- Maximize the ability of consumers to live in their own homes, to participate in community life, and to be engaged in the decision-making processes regarding their own care;
- Minimize reliance on institutional care (hospitals, nursing homes, and group living environments over 4 beds);
- Reduce acute/long term care costs primarily by lowering the need for acute care interventions (e.g. hospitalization), compared to the fee-for-service system. Additional objectives of the Partnership Program are to:
- Carefully document and research implementation. experiences and consumer responses;
- Develop and test quality assurance protocols and quality indicators based on the expressed values of consumers;
- Develop and implement a self-sustaining system of program and organizational development, model improvement and replication;
- Create a design whose essential elements can be applied to multiple age and target groups in various geographic settings, urban and rural.

IV. Target Populations

The Partnership Program will serve individuals who meet Medicaid "level-of-care" criteria for nursing home admission. Participants in the Partnership Program for Elderly People must be age 65 or older and be dually eligible for Medicaid and Medicare. (We will also develop a detailed plan for extending the Elderly Partnership to people who are not Medicaid eligible. Due to the need for special approval by the Wisconsin Insurance Commissioner, we cannot assure that this "private pay" component will be implemented before the end of the three-year grant period.) Participants in the Partnership Program for People with Physical Disabilities must be age 18-64 and meet the 1973 Rehabilitation Act definition of "physically disabled" (See Appendix 1, Glossary for definition and Appendix 5, Attachment l, Table 1 for a breakdown of the expected frequency of disabling conditions).

V. Program Implementation Sites and Timelines

Elder Care of Dane County, a community-based not-for-profit organization which provides services to elderly people in Dane County, will implement the Partnership Program for Elderly People. Elder Care will enroll 90 people phased in over about two and one-half years. Based on early experiences at the Elder Care site, we will issue a request for proposals for testing the model at a second site. The Milwaukee PACE site, now well established in its fifth year of operation, has expressed strong interest. A second elderly Partnership site will be selected no later than the beginning of the second project year. If early experiences in the model are promising, we will test the viability of our program development and replication strategy by preparing this second site to accept enrollees before the end of the Robert Wood Johnson grant period.

In mid-1994 we will invite proposals from the Independent Living Centers in Wisconsin to develop the Partnership Program for People with Physical Disabilities. The requests for proposals will be directed toward the three Independent Living Centers which have the strongest organizational capability and which are also certified under Medicaid as personal care providers. They are located in Dane, Milwaukee, and Racine Counties (see Appendix 14, Administrative Structure; Appendix 15, Special Issues for Independent Living Centers).

Considerable planning with the three Independent Living Centers has already been accomplished through an RWJ planning grant. We will select one primary and one secondary site. The secondary site will participate in all planning and development activities so that later replication can be accomplished more easily. The first project year will be devoted to further design and service delivery with 20-30 volunteers and improving the model. Appendix 16, Initial Workplan Timeline, itemizes some of the planning and pilot-testing tasks which we will undertake with the selected Independent Living Centers.

VI. Key Features of the Partnership Program

We have divided our discussion of key features of the Partnership Program into the following sections the multidisciplinary team; program services; initiating relationships with primary care physicians; enrollment and recruitment of participants; special program features of the program for people with disabilities; capitation and risk management; and, program research.

A. The Multidisciplinary Team

The multidisciplinary team is the heart of the Partnership Program. At the core of the team are the consumer, a social worker or Independent Living Coordinator, and a nurse practitioner.

Other team members involved in the consumer's care include the primary care physician, personal care worker, physical and/or occupational therapist, dietician, durable medical equipment specialist, and other appropriate specialists. Two important objectives of the team are to:

- Improve/maintain the health status and quality of life of the consumer; and
- Reduce the need for institutional., high cost medical services, thereby lowering the cost of care

Like PACE, success of the Partnership Program will depend on effective working relationships among core team members. In order to encourage this, most team members will be Partnership Program employees. Unlike PACE, however, the primary care physician will be employed in an HMO, hospital, clinic, or private practice. This will create the need for an effective "bridge" . between the primary care physician and other team members.

The Partnership Program will emphasize the role of the nurse practitioner in bridging the gap between medical and social services so that fragmented services will be integrated. The following outlines several ways in which the nurse practitioner will achieve this goal:

- When an individual enrolls in the Partnership Program, the multidisciplinary team will conduct a comprehensive assessment of the person's life situation, condition, abilities, disabilities, informal supports, and personal lifestyle preferences.

As part of the comprehensive assessment, the nurse practitioner will perform a general health review. The health review will identify current and past health and health care experiences, problems, drug regimens, understanding of physicians' recommendations and degree of adherence to that advice, adverse health behaviors, depression, nutrition, current and past levels of physical and emotional functioning. The health review will help the team develop the overall care plan. It will help identify health conditions or behaviors which need to be addressed by the physician or more closely monitored by others. It will also allow the Partnership program to present itself, through the nurse practitioner, as a credible and immediately useful complement to the physician's care.

Shortly after the general health review, the. nurse practitioner will accompany the enrollee to an appointment with his/her personal physician. Information regarding the Partnership program will be provided to the physician prior to the office visit. The appointment may help with immediate health problems or with gathering additional information by way of a physical examination. This appointment will also create a forum in which the nurse ,practitioner may discuss the Partnership Program, including a description of the role he/she can play in advancing physician directives, monitoring consumer health care, and, in general, acting as an immediately useful complement to the physician's care.

The Partnership Program as a whole, and the nurse practitioner role in particular, will be structured to offer the following benefits to physicians:

1. Access to comprehensive, up-to-date information about the consumers medical condition and current health status;

2. Assistance of a competent nurse practitioner and entire multi-disciplinary team in caring for individuals with complex care requirements;

3. Health monitoring on an on-going basis and special attention during times of high risk such as post-hospitalization periods);

4. Improved communication with consumers, their families, and with other service personnel involved in the consumer's care;

5. Access to timely information from service providers who see the consumer on a daily or weekly basis;

6. Improved compliance with prescribed treatment regimens;

7. Relief from routine and non-critical telephone calls from consumers and family members;

8. Less bureaucracy and paperwork;

9. Assistance with vexing non-medical problems which interfere with medical treatment or which help cause medical problems (e.g.. poor housing, environmental hazards, transportation problems, nutritional deficiencies, loneliness, elder abuse, etc).

The relationship between the consumer, nurse practitioner, and primary care physician will be built, one person at a time, through repeated interactions. It will be strengthened by evidence that the Partnership Program is of value to both physician and consumer. Demonstrating such value will be the challenge which the Partnership must meet and which we will research and document.

Comparison of the Multidisciplinary Team for the Two Partnership Models, The basic team features and processes described above apply to both the Partnership Program for Elderly People and the Partnership Program for People with Physical Disabilities. The team composition and consumer role, however, will vary depending on the care needs and preferences of the target group. For example, in terms of team composition, the physical disabilities team will include the following members:

- An Independent Living Coordinator, will replace the social worker *of* the Partnership Program for Elderly People. The IL coordinator will be a person with physical disabilities whose primary responsibilities will be to develop methods by which each consumer's self-help and self-reliance capabilities may be maximized;

- An Assistive Technology Specialist, whose command of the latest technological applications will be available to advance the skills of the consumer;

- A Peer Advisor, available if desired by the consumer, will be a person with physical disabilities, not employed by the Partnership Program, specially trained to offer confidential consultation informed by his/her own life experiences;.

- Specialists as Primary Care Physicians, available as an option to people with disabilities because many have difficulty finding a primary care physician knowledgeable or comfortable in working with physical disabilities and many physicians do not have, admitting privileges at rehabilitation hospitals.

In terms of the process of team functioning, the physical disabilities model will expand opportunities and responsibilities which reinforce the consumer role and the independent living focus of the model. For example:

- Care Planning: The team process will engage the consumer to assume responsibilities to identify needs and to create answers to them. For example, a consumer may be challenged to use available resources (such as directories, contact lists, transportation, and attendant care) to research and personally investigate prospective housing opportunities, rather than have other team members do the primary work of locating suitable, accessible housing. The simple act of installing a telephone in the room of a nursing home resident who wishes to be relocated to the community has, in our experience, been instrumental in enabling persons with physical disabilities to assume increased responsibilities in their own care planning.

Service Delivery: The consumer will be challenged to discover means by which he or she may willingly assume responsibilities which would otherwise require paid service staff. For example, the consumer will be given the opportunity to take responsibility for learning more .about his/her disease progression, risks, and self-care techniques. The opportunity to assume responsibility as employer of one's own personal attendants, (including scheduling, planning, recruiting and training), will be available to consumers who are trained, willing, and competent to act in such a capacity.

Additional information about the multidisciplinary teams is available in Appendix 10, The Multidisciplinary Team - Partnership Program for Elderly People; and Appendix 13 The Multidisciplinary Team, Partnership Program for People with Disabilities.

B. Partnership Program Services

The Partnership Program will provide benefits at least equal to those offered in Medicare, the Wisconsin Medical Assistance Program **and** Medicaid Home and Community-Based Services (HCBS) waivers. In addition, each eligible and interested applicant may receive a comprehensive assessment and community care plan without obligation for personal payment or enrollment in the program.

Acute Care and Administrative Functions: For both Partnership programs, we will contract with a provider network or with a Health Maintenance Organization for essential acute care services and for related administrative functions, depending on the organization of the health care system in that area. This will speed program implementation and offer:

- Immediate access to a full network of primary care providers, clinical services, referral specialists, and hospital care;

- Established protocols. governing referral patterns, utilization and review.;

- Claims processing, storage and retrieval, appropriateness review, provider appeal, tracking, and reporting capabilities.

A discussion of the details for handling the above tasks is contained in Appendix 2, Health Care Systems Analysis. After an initial phase-in period, contracts with additional networks or HMOs will be added in order to offer participants full choice of primary care physician.

Clinical/Functional Outcomes: Both Partnership models will include an assertive program of health maintenance designed to reduce the need for acute or long term care by preserving the health and well-being of consumers. Examples of areas which will receive particular emphasis are:

- Early Detection and Intervention: Careful monitoring for signs of developing illness will increase the probability for timely intervention. The active role of the nurse practitioner in both Partnership models will facilitate early detection. We will also attempt to incorporate responsibility for health care monitoring into the roles of all team members. We will undertake (a) special training of personal care workers regarding indicators of impending illness or disease progression, and (b) education of consumers in self-monitoring and self-reporting of symptoms.

- Exposure to Risk Factors,: Each assessment conducted by the multidisciplinary team will include a review of risk factors salient to the consumer. Each care plan will include a strategy for limiting or reducing exposure to these risk factors. Approaches may include environmental (e.g. housing hazards), social (e.g. elder abuse, isolation), behavioral (e.g. alcohol or drug abuse), psychological (e.g. depression), or lifestyle factors.

- Medication Management: In the general health review conducted by the nurse practitioner at the time of enrollment, issues of medication management will be emphasized. The nurse practitioner will follow-up and work closely with the consumer's physician to reduce polypharmacy, improve adherence to prescriptions, and increase attention to the most appropriate prescription practice. The objective of this strategy is to reduce the chance of medication-related hospitalization illness, or disability.

- Hospital Transitions,: The consumer's care plan will address hospitalization instructions to meet the need should it arise. Team members will also be actively involved in planning for hospital discharge to ensure appropriate and effective transitioning to post-hospital care for each individual. The fact that consumers will not be "disenrolled" from the program when hospitalized represents considerable progress toward continuity of care compared to the current system.

Terminal Care Preparations: Each model will develop precise procedures for careful application of advanced directives to reduce unwanted, high-tech terminal care.

C. Initiating Relationships with Primary Care Physicians

We plan three complementary approaches to initiating Partnership Program relationships with primary care physicians.

1. Enroll Participants: People enrolling will automatically bring their personal physician into a relationship with the Partnership Program. Therefore, recruiting participants is one method of initiating physician relationships. This approach. has the advantage of being direct, efficiently targeted and consumer-centered. One disadvantage is that building relationships and arranging appropriate contracts with many different HMOs or networks takes time. Therefore a phase-in strategy is advisable. Approach 2 below is such a strategy.

2. HMO Contract: We will contract with an HMO or hospital network for essential acute care services. This will provide immediate access t a substantial number of physicians. We plan to work first with those physicians already serving [g] a sizable number of people who are on the wait list for the Community Options Program and are interested in the Partnership Program. Later we plan to expand to physicians in other HMOs so that full physician choice is available to consumers. This sequence of events is a phase-in approach and not program policy. Even in the early stages of implementation, we will accept enrollees whose physician is affiliated outside the contracted HMO, if program capacity permits and the necessary contracts can be arranged with that physician's HMO, clinic, or network.

3. Other HMO/Physician Initiated Referrals: We will also market the Partnership Program to other HMOs through seminars, written materials, and individual physician meetings.

Additional enrollment and marketing plans, along with preliminary provider network analyses are described in Appendix 2, Health Care Systems Analysis.

D. Enrollment and Recruitmentt of Participants

Enrollment in the Partnership Program will be voluntary. Disenrollment for consumers will be voluntary with a one-month notice. The provider organization will be prohibited from disenrolling a consumer except under specified conditions when he or she refuses to adhere to important aspects of service regimens or terms of participation.

The Partnership Program will employ the following primary approaches to recruitment of participants:

1. We will invite elderly people in the **Community Options Program** (COP) or on the COP wait-list who express an interest in managed care to participate in the Partnership Program for Elderly People. This currently includes 384 elderly people enrolled in COP and over 600 elderly people on the wait-list. The Community Options Program (described in Appendix 19, Program Descriptions) has a well-established, statewide referral network.

The COP wait-list will also provide the priority target group for the Partnership for People with Physical Disabilities. Market analysis indicates a reasonably large market of potential enrollees in the three counties where ILCs which meet the organizational criteria for prospective sites are located:

Source of Enrollees- Partnership Program for People with Disabilities	**Dane County**	**Milwaukee County**	**Racine County**
Current COP Participants	267	309	598
COP Wait-Listed	531	300	534
SSI-Disabled Recipients	11,755	51,964	17,748

People on the COP wait-list will be a priority for both Partnership models since a) they are already assessed to meet nursing home level-of-care and Medicaid financial eligibility requirements and b) they are struggling with services, either in the community or in nursing homes.

2. We will establish **close working relationships with major referral sources.** Particular emphasis will be placed on working with area hospitals so that Partnership Program options are fully explored with likely nursing home candidates. In Dane County, between 50% - 70% of new nursing home admissions for the elderly come directly from hospitals. The Hospital Link initiative (described in Appendix 19, Program Descriptions) is one tested method which will be used in Dane County to begin to achieve hospital connections. In addition to area hospitals, the Partnership Program Agency will establish referral procedures with physicians in the network of contracted primary care and specialty physicians.

3. **The State will assist the Partnership Program with mailings** or other contacts with targeted groups, such as elderly SSI recipients, Medicaid recipients, or nursing home residents.

4. The Partnership Program will be **marketed to the general public.**

We expect that, over time, a fifth method will evolve which may prove to be the most effective **word-of-mouth promotion by satisfied participants.**

Special Program Features - Partnership Program for People with Disabilities

The essential quality we seek is **participation** by individuals with physical, disabilities--not so much "involvement" or "consultation" as the sharing of decision-making and responsibility. We seek participation not because it is trendy but, because it is essential to program effectiveness. Consider the following:

• Long term care accounts for over 63.3% of combined Medicare/Medicaid expenses and 73.9% of Medicaid-only expenses for people with physical disabilities in our sample. In fact, four long term care services (personal care [41.2%], home health [15.0%], durable medical equipment [6.4%], and transportation [3.5%]) account for 66.1 % of Medicaid-only expenditures. Long term care (in particular, this set of four services) is most affected by personal decisions about lifestyle and behavior (see Appendix 5, Table 4, Cost and Service Utilization).

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• While physician and hospital costs account for only 13.2% of average -Medicaid-only expenditures, they too are very affected by personal behavior and self-care capabilities of the. consumer involved. Avoidable hospitalization due to dehydration or decubitus ulcers or bladder. infections are examples. In a Washington, D.C. survey of people with physical disabilities who had previously been hospitalized, about 25% of all respondents (and 50% of those with a spinal cord injury) felt some of their hospitalizations could have been avoided (DeJong 1989).

• Abuse of alcohol or other drugs occurs at about 2-3 times the rate for the general population. It is worse among individuals with a spinal cord injury: forty-nine percent (49%) of such individuals who responded to a Wisconsin survey self-reported that they were either heavy (24%) or moderate (29%) users of alcohol (Buss and Cramer, 1989). Efforts to reduce the problem of alcohol abuse can be accomplished only through the active engagement and participation of affected individuals and their peers.

• Informal support remains as critical to the care and well-being of this population as the expenditure of public funds. Those public expenses increase whenever there is a breakdown of the informal support network. Departure of a spouse is one example. Participation by family members in care planning is therefore critical. The formal care planning process must regularly elicit information about what caregivers need and must make provisions to enlist and safeguard those supports (e.g., by ensuring that the person with a disability does not become a patient to the spouse).

• Rules or professional protocols designed to control service utilization are difficult to develop and to apply when individuals have very extensive, chronic disabilities. For example, how many hours of personal care per day are "just right?" An important question is whether a program can enlist affected individuals to make their own decisions which self-limit service utilization and conserve resources for use by others.

In consideration of the above, we will emphasize the creation of specific processes and roles through which individuals with a disability may contribute, exercise choice, and assume responsibility (See examples, Appendix 9, Mechanisms for Consumer Involvement).

Administrative Structure of the Partnership Program for People with Disabilities

We propose that objectives and basic elements be common to both models of the Partnership Program. However, the structures and processes which support opportunities for self-determination, self-expression, identity development, self-care, and choice of life style esteemed by the target population of younger persons with physical disabilities require an administrative organization uniquely experienced with these values. For example, the national debate over whether the advocacy role of Independent Living

Centers (ILCs) may be compromised by providing services indicates that we should pay special attention to organizational structure and sponsorship.

After consideration of the above issues, we identified the following three administrative options for potential program providers for the Partnership Program for People with Physical Disabilities:

1. Direct administration by an Independent Living Center (ILC) which meets the Federal Title VII of the Rehabilitation Act, and currently provides or is planning to provide personal care services under Medicaid.

2. A non-profit subsidiary of an ILC, which provides for separate legal liability and financial accountability while maintaining the ILC's decision-making control.

3. A non-profit organization which is affiliated with, but not controlled by, an ILC, and which has a consumer-controlled governing board.

In the RFP process which will determine the provider for the Partnership Program for Physics Disabilities, critical issues regarding the legal, financial and governance implications of each option will be examined. In addition, we will consult with a national panel of independent living experts to examine and critique approaches for providing both advocacy and service, and for developing new consumer leadership.

Additional information regarding special program issues may be found in Appendix 9, Mechanisms for Consumer Involvement; Appendix 14, Administrative Structure - Partnership Program for People with Disabilities; and, Appendix 15, Special Issues for Independent Living Centers.

F. Capitation and Risk Management

Existing funds from our current s.1915(c) Medicaid waiver (Home and Community ;Based Services) and state-funded Community Options Program will provide initial service funding. This will be followed by full Medicaid capitation under s.1915(a) of the Social Security Act before the end of the first project year. The same **Medicaid** capitation methodology will be used for the Partnership Program for Elderly People as is used for our existing PACE sites. We will also apply to the Health Care Financing Administration (HCFA) for a **Medicare** waiver. We have had very encouraging discussions with HCFA regarding the possibility 'of obtaining the waiver. We hope to implement the Medicare waiver in .the third year of demonstration of the Partnership Program for Elderly People.

We have not yet settled on capitation methods for either Medicaid or Medicare in the Partnership for Persons with Physical Disabilities. Development of such methods will be a product of the first year of the proposed RWJ grant. Appendix 5, Cost and Service Utilization, contains our initial analysis of costs and issues relevant to capitation for this population.

Risk management issues are explored in Appendix 8, Risk Management Analysis. One important aspect of risk management will be contractual risk-sharing arrangements with the State of Wisconsin similar to those employed by PACE. We will employ one of the various options discussed in Appendix 3, Capitation and Risk Sharing Options.

G. Partnership Program Research

We will conduct research in three basic areas:

1. **Consumer Cost and Service Utilization Patterns:** Cost and service utilization patterns will be tracked for each consumer and results will be analyzed for both Partnership models to determine (l) trends over time for specific individuals and groups of individuals within the same Partnership model; (2) patterns of service use and costs; and (3) comparisons with service use by other groups or other programs (e.g. between the two Partnership models, between either Partnership model and nursing homes) (See Appendix 5, Cost and Service Utilization).

2. **Physical and Emotional Functioning of Consumers:** Measurements will be made at enrollment and at periodic intervals thereafter for each consumer in the Partnership for Elderly People. A description of the various standardized instruments to be used can be found in Appendix 6, Part IV, Quality and Research. These measurements will not be conducted for participants in the Physical Disabilities Partnership since only a short pilot-test phase is proposed for that model.

3. **Quality, as defined by Consumers and Providers:** Research on quality is essential to Partnership Program design, development, and model improvement: Through formative research in both Partnership Program models we will elicit, organize and analyze information obtained directly from consumers and direct care providers (See Appendix 6, Quality and Research). The research will be an important aspect of feedback processes necessary for organizational learning to occur. There will be six components of our research efforts in the area of quality.

Component I - Values,

By "values" we mean those things which people hold in esteem for their own sake. Examples may include safety, health, privacy, choice, self-determination, autonomy. Through individual and group interviews, we will identify and analyze the values held by program consumers and direct care providers such; as physicians, nurses, social workers, personal care workers.. Consumers and providers construct their mental models of overall quality from these values and thereby judge the services they receive or render. An understanding of the role of values is critical to conflict resolution methods, multidisciplinary team functioning, and interfaces between acute and long term care and quality assurance systems.

Component II - Conflict Resolution

Conflict resolution methods will be vital to any effort to integrate acute and long term care or to maintain cross-site continuity of care. In this component we will investigate the nature and source of conflicts and explore methods used for conflict resolution as the Partnership Program gains experience.

Component III - Organizational Structure and Management Practice.

In this component we will examine how structure and practice affect the ability of both Partnership models to (a) elicit information, advice, and participation from consumers and (b) incorporate consumer advice and values.

Component IV - Interfaces and Transitions

Through individual and paired interviews we will examine three sets of relationships which partly define the interfaces between acute and]on term care systems: the physician, consumer, nurse practitioner relationships.; the social worker, consumer, nurse practitioner relationships; the personal care worker, supervisor, consumer relationships. Researchers will also follow consumers across service sites, gathering information about both the consumers' and providers' perceptions of events and decision-making. This information will be used to develop improved protocols for interfaces and transitions.

Component V - Personal Care Workers

In situations where personal care workers assume more than usual decision-making responsibilities relative to consumer care, their efforts are frequently thwarted by confusion over the competing values of the primary physician, the consumer, and the personal care worker. Personal care workers are frequently unprepared to act appropriately in these situations.. Information obtained through this research component will be used to improve training programs for personal care workers and their supervisors.

Component VI - Quality Assurance and Quality Improvement

The Partnership. Program research will assess conventional quality assurance methods, develop quality improvement methods, and attempt to develop an integrated oversight strategy that maintains the maximum benefits of both approaches. We will use the strategy to develop a model contract for use by the State of Wisconsin and other regulatory agencies engaged in contractual relationships with managed care organizations.

Research Strategy and Methods

The Partnership Program will use a formative evaluation field research design. The primary methods of the Partnership Program research will be interviews and participant observation. These methods are well adapted to the study of quality, and conducive to the study of home and community-based care. Data will be obtained directly from consumers and direct care providers. Timing of data collection will be triggered by both key events (e.g. hospitalization) and by predetermined time intervals. Data collection will be conducted at the beginning, during, and at the end of a consumer's participation in the program, and will occur in wide variety of settings and situations. The Partnership Program will create function or occupation-specific focus groups to evaluate research strategies and practices. All participants in the Partnership Program will be invited to participate in interviews and observations, and participation will be voluntary.

VII. Program Barriers, Development, Replication

Significant barriers confront organizations which attempt to develop integrated care models such as those of the Partnership Program. Examples include high start-up costs, extensive learning, education and problem-solving challenges, development of organizational competence, and the need for extensive support from the external state and local environments. As described in Part VI, Section F - Capitation and Risk Management, the Partnership Program will specifically need to address regulatory barriers regarding exemption from the Office of the Commissioner of Insurance from state HMO licensure requirements, and obtaining a Medicare waiver from HCFA The Medicare capitation method used for PACE will probably be used for the Partnership for Elderly People. We will work with HCFA and the Medicaid Working Group to establish Medicare capitation methodologies for the Partnership for People with Physical Disabilities.

We will develop, implement, and document a program development process which will address these barriers and provide the basis for expansion and replication of the models The strategies of the program development process will increase the chance of success for the Partnership Program, document what works and what "does not work in the models, reduce the general barriers to program development, and provide techniques for replication of the models in Wisconsin and other states. Key elements of the process include:

Start-Up Service Funding: We will demonstrate how s.1915(c) Medicaid waivers may be used to provide pre-capitation start-up funding for services. This finance technique is particularly relevant to replication in other states since 48 states now employ home and community-based waivers. We will then demonstrate Medicaid capitation methodologies using s.1915(a) before adding Medicare capitation.

Program Development Fund.: We will incorporate language into contracts with the two new Partnership programs, as well as with the existing PACE programs, which will require specific contributions to a program development fund from established providers. The program development fund will be used to provide technical assistance, training, and start-up resources for existing or new providers.

Risk Management: We will design and implement a risk management strategy for community-based -based organizations which includes: (1) a defined role for Wisconsin counties; (2) insurance, joint risk reserves, or reinsurance among related programs (e.g.. Partnership, PACE); (3) contractual risk-sharing methodologies between the provider, county, state, and federal government; (4) contractual methods to preserve program integrity. We will develop a **Guide to Risk Management** for community-based organizations to use in designing risk management strategies.

Development of Model Contracts,: We will draft a model contract for services between the DHSS and the Partnership Program agency which will serve as a "boilerplate" contract for Partnership Program replications. We will also develop a model contract for support services within the network of ancillary service providers.

Technical Assistance: We will develop a technical assistance system with existing providers of long term care or acute care to provide training and problem-solving assistance to the Partnership models. State, county, and University of Wisconsin officials will participate. The Milwaukee PACE site, if approved by On Lok to become a Technical Assistance Center for PACE will employ its knowledge of PACE to provide help for the elderly and the physical disability Partnership models.

Manuals and Guides: We will develop manuals and best practice guide's to assist both existing and new providers. This will also help reduce the amount of "re-learning" which occurs with each new site or even each new staff person. The manuals will include information on the following: (1) clinical protocols; (2) service team functioning and structure; (3) organizational development;. (4) marketing; (5) quality assurance ,strategies; (b) finance. Based on our research results we will also develop technical assistance materials covering significant interfaces in the model, such as acute and long term care connections (especially the physiciannurse practitioner relationship) and cross-site transitions (e.g. hospital-home-nursing home).

A Project Advisory Group, consisting of fifteen expert members in the fields of geriatrics and services for people with physical disabilities, will be convened frequently to review and guide design and research efforts. A National Review Group will also be convened towards the end of the second and third years of the demonstration to review experiences in both models.

The truly significant barriers we face are inherent in the Partnership Program itself - integrating acute and long term care, managing the interface between delivery systems and sites, building organizational capacity, etc. These challenges require the type of partnerships we are forging between Wisconsin and the Robert Wood Johnson Foundation; between the Department of Health and Social Services and University of Wisconsin School of Medicine and School of Nursing; between state and counties; between different constituencies (elderly and people with physical disabilities); and, between public and private entities such as HMOs, Elder Care, and the Independent Living Centers.

VIII. Conclusion

By virtue of our experiences in community-based long term care and in managed care for acute health services, Wisconsin is uniquely qualified to demonstrate that effective integrated care programs are possible, and that innovative quality improvement approaches can lead to better health care delivery programs..

We are facing a time of historic choices in health and long term care. With a well-conceptualized, researched, sequence off actions we will be able to effect system changes which hold the potential for eliminating continued struggle with a costly, fragmented, fee-for-service system. Towards this end, we wish to build on our experience and tradition of innovation in Wisconsin by solidifying our relationship with the Robert Wood Johnson Foundation in the successful demonstration of the model for elderly people and model for people with physical disabilities in the Partnership Program.